

EMERGENCY CARE REQUEST

Name _____ Village _____

Address _____ Telephone # _____

Date and time of request _____

Name and birth date of applicant _____

Date(s) and time(s) emergency care is requested (Maximum of one 4 hour visit per week plus one additional 4 hour visit every 28 days)

Describe your physical limitations, medical problems, and special needs _____

Name, relationship and telephone number of person to be contacted in case of an emergency

Do you have a Do Not Resuscitate (DNR) document signed by a doctor? Yes No

Is there a current and completed vial of life in refrigerator door? Yes No

Have you previously received emergency care under this program? Yes No

If yes which agency provided the care? _____

If yes do you want to continue with this agency? Yes No

If yes when was the last date emergency care was provided? _____

**THE EMERGENCY CARE PROGRAM IS FUNDED
BY THE
SUN CITY ROSEVILLE FOUNDATION**

HOME CAREGIVER RELIEF REQUEST

Professional paid employees of Home Care Agencies will provide ALL caregiver relief. THE FOUNDATION WILL PAY FOR ONE FOUR-HOUR VISIT EACH WEEK AND ONE ADDITIONAL FOUR HOUR VISIT EACH FOUR WEEKS MINUS A CO-PAY BY ME OF \$5.00 PER HOUR. I FURTHER AGREE TO PAY THE PROVIDING PROFESSIONAL ORGANIZATION ALL COSTS FOR ANY ADDITIONAL HOURS I CONTRACT FOR. THIS BENEFIT IS NOT PAID FOR BY THE ASSESSMENT THAT I PAY AND IS NOT A SERVICE TO WHICH I AM ENTITLED AS A MEMBER OF THE ASSOCIATION OR THE FOUNDATION. THIS PROGRAM IS SOLELY FUNDED BY THE SUN CITY ROSEVILLE FOUNDATION. By making this request, I understand that a confidential file will be kept including this application and other written notes regarding the history, health and general conditions of the care receiver. This record is confidential and will be seen only by the professional agency staff and designated caregiver relief personnel. It will not be released to any other person or agency without my written consent. I can cancel this service at any time.

RECEIVED AND READ

Signature _____

Date and Time _____

IMPORTANT: You must complete another request for Caregiver Relief if you need additional relief at the conclusion of the approved dates contained in this report.

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